DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #03-25

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.726 and Social Security Act Section 1924

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 4,295
b. FFY 2004 $ 32,397

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 3 to Attachment 3.1-A
Pages 2 & 5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 3 to Attachment 3.1-A
Pages 2 & 5

10. SUBJECT OF AMENDMENT:
Program of All-Inclusive Care for the Elderly (PACE)

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Janet Schalansky – signature//

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary of Social & Rehabilitation Services

15. DATE SUBMITTED:
September 17, 2003

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 17, 2003

18. DATE APPROVED:
December 2, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
Associate Regional Administrator for DMCH

23. REMARKS:

D. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the state's approved HCBS waiver(s).

Regular Post Eligibility

1. __X__ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

a. Sec. 435.726—States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one):
1. _N/A_ The following standard included under the State plan (check one):
(a) ____ SSI
(b) ____ Medically Needy
(c) ____ The special income level for the institutionalized
(d) ___ Percent of the Federal Poverty Level: ___
(e) Other (specify): _____
2. _X_ The following dollar amount: $ _716_____
Note: If this amount changes, this item will be revised.
3. N/A The following formula is used to determine the needs allowance: _____.

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.

1. ____ The amount is determined using the following formula:_____
2. ____ Other
3. ____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. __X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). N/A The following standard included under the State plan (check one):

1. ____ SSI
2. ____ Medically Needy
3. ____ The special income level for the institutionalized
4. ____ Percent of the Federal Poverty Level: 100%
5. ____ Other (specify): _____

(B). X The following dollar amount $ 716
Note: If this amount changes, this item will be revised.

(C). N/A The following formula is used to determine the needs allowance: _____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe this amount is reasonable to meet the individual's maintenance needs in the community: _____